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Domestic abuse as a transgressive practice: understanding nurses' responses through the lens of abjection

Abstract:

Domestic abuse is a worldwide public health issue with long-term health and social consequences. Nurses play a key role in recognizing and responding to domestic abuse. Yet there is considerable evidence that their responses are often inappropriate and unhelpful, such as trivializing or ignoring the abuse. Empirical studies have identified several reasons why nurses' responses are sometimes wanting. These include organizational constraints, for example lack of time and privacy; and interpersonal factors such as fear of offending women and lack of confidence. We propose however, that these factors present only a partial explanation. Drawing on the work of Julia Kristeva, we suggest that alternative understandings may be derived through applying the concept of abjection. Abjection is a psychological defence against any threat (the abject) to the *clean* and *proper* self that results in rejection of the abject. Using examples from our own domestic abuse research, we contend that exposure of nurses to the *horror* of domestic abuse evokes a state of abjection. Domestic abuse (the abject) transgresses established social boundaries of clean and proper. Thus when exposed to patients' and clients' experiences of it, some nurses subconsciously reject domestic abuse as a possibility (abjection). They do this to protect themselves from the horror of the act, but in so doing, render themselves unable to formulate appropriate responses. Rather than understanding the practice of some nurses as willfully neglectful or ignorant, we argue that through a state of abjection, they are powerless to act. This does not refute existing evidence about nurses' responses to domestic abuse. Rather, as a relatively unknown concept in nursing, abjection provides an additional explanatory layer that accounts for why some nurses respond the way they do. Crucially, it elucidates the need for nurses to be supported emotionally when faced with the transgressive practice of abuse.

Key words: abjection, disgust, domestic abuse, horror, nursing, responses.

Introduction

Domestic abuse (known also as ‘domestic violence’ or ‘intimate partner violence’) is a worldwide public health issue. It is defined as: ‘Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial [or] emotional’(Home Office 2012). Domestic abuse can be perpetrated by women against men (Flinck & Paavilainen 2010), or within same-sex relationships, but figures suggest that 90% of domestic abuse is committed by men against women (Department of Health 2005).

Domestic abuse tends to be under-reported which makes assessment of its prevalence problematic. Caution needs to be exercised in using domestic abuse statistics as they can only ever present a partial picture of the scale of the problem. However, findings from a 10-country study are indicative of its extent: worldwide the prevalence for women who experience physical or sexual violence at the hands of a male intimate partner ranges from 15%-71% (World Health Organization 2012).

The relationship between domestic abuse and poor health is widely recognized. It has serious, long term health and wellbeing consequences for women who experience it and also impacts on their children. In fact, its toll on health is greater than those caused by either smoking or obesity (Vos et al., 2006, Humphreys et al., 2008). It is unsurprising therefore that domestic abuse is considered an *urgent* public health priority (Garcia-Moreno & Watts 2011, Bacchus et al. 2012).

Nurses (in this paper we use ‘nurse’ as a generic term to include midwives and public health nurses) play a key role in recognizing and responding to domestic abuse and in facilitating

the safety of women (and her children) (Dickson & Tutty 1996, Bradbury-Jones et al. 2011). Yet there is considerable evidence that they do not always do this effectively or appropriately. In terms of recognition of domestic abuse, many nurses are reluctant to discuss the issue with women (Mezey et al., 2003, Lazenbatt et al., 2005, Salmon et al., 2006, Gutmanis et al., 2007, Lazenbatt et al., 2009, Lazenbatt & Thompson-Cree 2009, Montalvo-Liendo 2009, Bacchus et al., 2012, Beynon et al., 2012, *author reference*). Similarly regarding responses to disclosure of domestic abuse, studies have pointed consistently to many nurses' inadequacies, such as failing to provide practical support (Peckover 2003) or ignoring the abuse (Bacchus et al., 2002, Lazenbatt et al., 2009). There is even evidence that some nurses have ignored abuse when they have witnessed their patients/clients experiencing it directly (*author reference*). A number of reasons have been identified for why nurses' practices regarding domestic abuse are sometimes wanting. For example, interpersonal factors such as unwillingness to pry (Henderson 2001) or fear of offending women (Salmon et al., 2006, *author reference*) and organizational constraints, particularly lack of: time (Mezey et al., 2003, Salmon et al., 2006, Buck & Collins 2007), privacy (Bacchus et al., 2002, Mezey et al., 2003) and training (Bacchus et al., 2002, Salmon et al., 2006, Buck & Collins 2007).

Existing evidence explains the apparent failings of many nurses' recognition and responses to domestic abuse as attributable to a range of interpersonal and organizational factors. We argue however, that this presents only a partial explanation and offer a new lens through which domestic abuse recognition and responses can be viewed. Using illustrative examples from our own domestic abuse research and drawing on the work of Julia Kristeva (1982), we suggest that alternative understandings may be derived through the concept of abjection. We have used what Puig de la Bellacasa (2012) describes as 'thinking with' Kristeva's notion of abjection. The proposed theoretical perspective provides an addition explanatory layer to

account for why some nurses respond the way they do when faced with domestic abuse. This does not refute existing evidence, but rather, it affords a hitherto unexplored angle from which this complex issue can be viewed.

Background

The abject and abjection: understanding the concepts

Abjection comprises three core elements that need to be understood in order to grasp the concept: 1) the clean and proper self (the non-abject); 2) matter that is excluded from the clean and proper self (the abject); 3) a reaction experienced when a person encounters the abject (abjection). The most notable writing on the issue comes from Julia Kristeva's analysis of the *Powers of Horror* (Kristeva 1982). From Kristeva's viewpoint, the abject is considered to be abject because it threatens the non-abject that is, the clean and proper. Her contention was that abjection is a psychological defence against anything that threatens self. She argued however, that it is not 'lack of cleanliness or health that causes abjection but what disturbs identity, system, order' (Kristeva 1982, p.4). The abject can be anything or anyone that does not fall within established boundaries of clean and normal (Holmes et al., 2006). The liar, the rapist, a friend who stabs you, any form of crime: these are examples of the abject (Kristeva 1982). Blood, faeces and vomit are key examples of matters that are likely to evoke abjection and can therefore be considered also as abject. Moments that incite abjection are those that disturb identity, system and order that do not respect borders and rules (McCabe & Holmes 2011). Abjection is thus a chaotic experience because it disrupts the clear system of order through which human beings secure and maintain their integrity (Jacob et al., 2009).

Finally in describing abjection, an important understanding is that the abject 'beseeches, worries, and fascinates desire' (Kristeva 1982, p. 1). It is both disgusting and irresistible, outraging and fascinating (Kristeva 1982). Therefore, the abject holds the capacity to threaten

but also to thrill; it disgusts and fascinates (Holmes et al., 2006), repulses and summons (Bradbury-Jones 2012). It may be difficult to comprehend how bodily substances such as blood and faeces, or a person such as a rapist or murderer, hold the capacity to thrill or fascinate. However, consider the phenomenon of ‘rubbernecking’ (drivers craning their neck to view the carnage from a road traffic accident), or the hours that some human beings give to reading and viewing the biographies of criminals such as Myra Hindley, Ronnie and Reggie Kray or Mark David Chapman. It then becomes apparent that a morbid fascination with the abject is an inherent human trait. Correspondingly, the concept of abjection resonates with experiences such as domestic abuse; a phenomenon that most people have not experienced, cannot comprehend and react to strongly. Yet, it is perhaps a phenomenon that sometimes simultaneously compels and fascinates.

Abjection and nursing

The concept of abjection is not well-known in nursing (Bradbury-Jones 2012) and it has become recognized only recently as something that directly affects nursing work (McCabe & Holmes 2011). Sick, disabled, smelly bodies, wounds, vomit, faeces etcetera are part and parcel of nursing work that threaten the clean and proper selves of nurses (Rudge & Holmes 2009, Bradbury-Jones 2012). Holmes and colleagues (2006) argue that nurses often experience disgust and repulsion in their practice and protecting the self from the unclean and polluted other is a reaction that every nurse experiences. However, these authors also contend that caring nurses are supposed to be able to sublimate such negative feelings and so they learn to present themselves in ways that hide the negative feelings evoked in their work. The façade is an important strategy to protect one’s own boundaries (Jacob et al., 2009). It involves what Rudge and Holmes (2009, p.181) describe as ‘shrinking from the abject’. But in this, there is perpetual repression of nurses’ negative feelings in favor of the clean, proper

and professional selves (Jacob et al. 2009). Overall, nursing can be viewed as a practice that is likely to evoke abjection (Parker 2004).

It is perhaps easy to understand how bodily substances such as blood, faeces and vomit might lead to abjection. But what person is capable of evoking such a state in a caring nurse? Quite simply, it is anyone who falls outside the boundaries of 'clean and proper'. Rudge and Holmes (2009) suggest that this may include, for example, homeless people or drug users. Of the limited literature on the subject within nursing, analyses of abjection have been undertaken in relation to: forensic psychiatric patients (Jacob et al., 2009); people with developmental disability (McCabe 2010); people with dementia (Holmes et al., 2010); people living on a ventilator (Lindahl 2011). McCabe and Holmes (2011) undertook a captivating analysis of how a child with a disability may evoke abjection in their own parents.

Overall, it is the different 'other' who evokes abjection. Invariably the other is attributed a negative value (Jacob et al., 2009) and 'othering practices' – such as marginalization and distancing – are common in nursing and healthcare (Hellzen et al. 2004, Johnson et al., 2004, Lagerway 2010). Abjection is concerned with repression and the experience of being an outsider, being excluded or ignored by the other' (Lindahl 2011, p.13). The notion of nurses' ambivalence or even negative inclination towards some patients is not new. Stockwell's (1973) ground-breaking revelations that nurses found some patients more difficult to deal with than others was uncomfortable for many. Her description of individual characteristics that made particular patients unpopular was a hard pill to swallow. But follow up studies have found the concept of social judgement in nursing remain salient (Johnson & Webb 1995).

Othering practices are the hallmarks of abjection and as Holmes and colleagues (2006) observe, when associated with transgressive practices, the intensity of the abjection is exacerbated. A transgressive practice is an act or behavior that contravenes those that are

socially acceptable or in Kristeva's terms, those that do not 'respect borders, positions, rules' (Kristeva 1982, p. 4). Although these are culturally bound and vary between different societies, there are certain practices that transgress most socially prescribed norms. Domestic abuse is one example.

The present study

Using excerpts from a recent study, we illustrate the ways that nurses' talk about domestic abuse as a transgressive practice and how in turn, this might evoke a state of abjection. Undertaken in the UK during 2010-2011, the study investigated primary healthcare professionals' responses to domestic abuse. Twenty nine health professionals were recruited from two health boards (regions) in Scotland using purposive sampling (midwives n = 11; health visitors (public health nurses) n = 16; general practitioners/family physicians n = 2). To be included, participants needed to have current or recent experience of working in a community setting and practice experience of responding to domestic abuse. Data were generated through individual, semi-structured interviews. Participants were asked to recall incidents from practice where a woman had disclosed domestic abuse. Data were analyzed according to the framework analysis approach of Ritchie and Spencer (1994).

The study findings are reported elsewhere (*author reference*). But influenced by the concept of abjection in nursing, we interrogated the individual interview transcripts of the 27 midwives and health visitors who took part. We were interested in nurses' responses and therefore data from two GP participants were excluded. We mined the data for nurses' references to domestic abuse as a transgressive practice. To do this we searched for adverbs and descriptors that we considered to be associated with abjection, such as 'awful', 'horrific', 'terrible'. It was not our intention to undertake a secondary analysis of data or to engage in a

discourse analysis. Rather, we sought a means to integrate illustrative examples into this discussion paper.

Abjection and domestic abuse

Domestic abuse can take many forms and as reflected in the opening definition, it includes a number of behaviors, including those that are controlling, coercive or threatening (Home Office 2012). When nurses in our study talked about the abused women they had supported, the words ‘horrible’ and ‘awful’ were used frequently to describe the women’s experiences. In the following exemplars, these have been italicized. One public health nurse told us:

[It was a] *horrible, horrible* situation for that girl with her new baby and the new relationship not working out because of the previous partner continuing to control and be abusive from afar affecting the new relationship. So that was a *horrible* situation and that situation got even nastier actually, the police were involved, guns were threatened, *awful* situation and mum felt quite threatened in all of this.

Many nurses, like society at large, find it difficult to understand why women who experience domestic abuse remain in the abusive relationship (*author reference*). Although there are well-documented reasons why this is the case, such as fear of the abuser, anxiety about living alone, financial dependence on the abuser, wishing to prevent family upheaval (Department of Health 2005), unwillingness to leave her children and because in spite of the abuse, they love their partner (World Health Organization 2009a). Overall, a woman’s responses are often limited by available options and while some women flee, others keep the peace by capitulating to their partner’s demands (Heise et al. 1999). One midwife in our study recalled her feelings of being horrified at a woman’s decision to stay with her partner:

She'd [client] been out and about and had bumped into an old male friend, so they went and had a cup of coffee in the local cafe and this was reported back to her husband... he beat the **** out of her and she said he had her pinned to the floor by her throat and he kept saying to her "Just admit it, I'll stop hitting you" and so eventually she admitted that she'd been having an affair with this guy who she'd met for one and a half hours to have a cup of coffee with. I was kind of *horrified* and I said "Why do you stay with him then?" and she went "Well he's always been the nicest guy I've ever gone out with" and I thought "By what measurement of someone's character? If he's nice to you, what are the others like?!"

Nursing is not exempt from the influence of cultural ideologies (Lagerway 2010) or immune from broader social assumptions (McCabe 2010). Nursing practice does not occur in a vacuum and nurses are exposed to the same cultural mores as the clients with whom they have contact. Domestic abuse is indiscriminate. It crosses socioeconomic, ethnic and geographical boundaries. Indeed, many nurses have themselves experienced abuse (Mezey et al. 2003, Wright 2003, Barnett 2005). It is unsurprising therefore, that they internalize dominant cultural norms regarding domestic abuse (Kim & Motsei 2002). This is reflected in the commonly held belief of many nurses that women are in some way responsible for their own abuse (Henderson 2001, Lazenbatt et al., 2005, Peters 2008, Thapar-Björkert & Morgan 2010, *author reference*). Abused women feel this too and some women in a study by Bacchus and colleagues (2002) commented that non-response of midwives post-disclosure was misinterpreted as confirmation that the woman was responsible for what was happening. Overall, as observed by Peters (2008), despite good empirical evidence that abused women are not masochistic and that perpetrators are not out of control, but rather maintain exquisite

control while psychologically and physically attacking their partners, myths that women must have an unconscious wish to be abused and that the abuser must have lost control, persist.

Lazenbatt and colleagues (2005) reported that most of the midwives (82%) in their study did not subscribe to the numerous stereotypical myths surrounding domestic abuse. However, in our study, nurses revealed a great deal regarding their assumptions about domestic abuse. They appeared to experience heightened horror when domestic abuse occurred among certain people. For example, one public health nurse described her reactions to a professional woman's experiences of abuse:

She talked through what she had experienced and it was quite *horrific* some of what she was describing the emotional abuse and I found it quite *disconcerting* to think that here was a highly intelligent articulate lady who was going through this *horrific* experience and was actually very isolated.

Similarly, a midwife described her surprise and horror at the level of abuse within a same sex relationship:

I was *horrified* at the amount of violence that went on within that woman-woman relationship. I was absolutely *gobsmacked* [shocked]... I mean honestly, think of all the *horrible* stories you've heard and just double it. It was just *incredible*.

So far we have discussed the horror experienced by some nurses when faced with the act of domestic abuse (particularly when it occurs among certain groups). Behind the appearance of tolerance and calm, nurses may experience dramatic personal responses when they come into contact with particular groups of clients or particular clinical situations (Holmes et al., 2006). Abjection results in a perpetual repression of nurses' negative feelings in favor of their clean,

proper and professional selves (Jacob et al., 2009). It is clear that exposure to women's experiences of domestic abuse has an emotional impact on nurses (*author reference*). In our study two midwives illustrated the emotional toil associated with such work:

It's only through sharing the experience and talking about it and getting the support of your colleagues, then it eases the *burden* to deal with it. But it is something that clearly *upsets* people you know when you realise that this is what is going on for so many women.

It has an impact. It has quite a strong impact... I don't go home and say to my husband "I had this poor girl who told me something really *awful*" because I can't tell him. I just say "I still feel a bit *sick* about somebody I looked after today" or "I need a bit of quiet I'm going for a walk".

Supporting women through domestic abuse experiences has been shown to be associated with significant emotional labour and requires nurses to 'show empathy without the tears' (*author reference*). Emotional labour involves the suppression of feelings in order to maintain an outward appearance that conveys to others a sense of being cared for (Hochschild 1983). It is associated with repression of feelings (Bradbury-Jones et al. 2010). In our study many nurses reflected on the personal emotional impact of dealing with domestic abuse situations, finding different coping strategies, such as going for a walk. Interestingly, very few participants mentioned expressing their feelings, or the availability of any formal supervision or debrief.

So far we have provided illustrative examples of the horror of nurses in relation to domestic abuse. However, reflecting on the primary focus of the paper, it may be too great a leap to argue that horror *per se* equals inappropriate responses to domestic abuse. What we can suggest however, is that the horror of which the nurses talk, is indicative of a state of abjection. Horror and abjection are inextricably linked. Holmes and colleagues (2006)

suggest that the nature of abjection is to retreat from the abject (even when there is extensive socialization to do otherwise). Controlling the abject is thus associated with a series of interventions that include: altered patterns of communication with patients (Parker 2004), distancing/lack of engagement (Hellzen et al. 2004, Holmes et al., 2006, Jacob et al., 2009, Lagerway 2010) and dismissal/disregard (Lagerway 2010, Lindahl 2011). With this in mind, there are sound theoretical reasons supporting the contention that when faced with the transgressive, horrific act of domestic abuse, many nurses experience abjection. As explained, retreating from the abject through distancing, dismissal etcetera is part and parcel of abjection. We believe this explains the well-documented dismissive, trivializing and indifferent manner of many nurses when confronted with domestic abuse (Bacchus et al., 2002, Lazenbatt et al., 2009, *author reference*). Overall, the façade associated with abjection may be important in securing one's own boundaries, but as Jacob et al. (2009) argue, it may result in 'impoverishment of care' (p. 158). Moreover, they argue that for nurses, powerlessness becomes an important issue because the power of the abject can be greater than the strategies deployed to protect oneself from it (Jacob et al., 2009).

Further, those who have written about abjection and othering have illuminated the scope of their negative impact, beyond distancing and disregard. Hellzen and colleagues (2004) suggest that the other can be neglected altogether. Similarly, Lagerway's (2010) analysis of patient as 'other' reveals how such patients easily fall to the 'margins of ethical responsibility' (p.594). This relates to the earlier discussion regarding emotional labour, with its characteristic behaviour of distancing. In her seminal work on the issue of emotional labour, Menzies argued that nurses distance themselves from those in their care as a means of managing anxiety (Menzies 1960). This provides additional explanations for why nurses sometimes ignore domestic abuse or why some believe that responsibility for domestic abuse lies with the woman herself. For women who have experienced domestic abuse however, to

be neglected completely or to fall outside the bounds of a nurse's ethical responsibility, poses significant risk. Lagerway (2010) argues that otherness as a nursing practice can have deadly consequences. Again, in relation to abused women, this is a salient point. In its most extreme form, domestic abuse kills women either through suicide (Campbell 2002, Devries et al. 2011), or homicide (Heise *et al.* 1999, Department of Health 2005, World Health Organization 2009b). In the United Kingdom, for example, it is estimated that every week, two women are killed by a current or former partner (Hester, 2009). Of course, the responsibility for women's mortality risk does not rest entirely with nurses. However, it does underscore the importance of their ethical responsibility in supporting abused women.

We have presented a negative account of domestic abuse responses among nurses, explained through the lens of abjection. But we now revisit the part of the abject that is capable of fascinating desire (Kristeva 1982). Evans (2010) refers to the 'strange yet compelling' nature of nursing. Importantly she points out the vagaries of abjection. In one situation, a particular nurse may find something repulsive, while another does not. Or one is frozen and unable to act in an emergency situation, while another nurse is able to act.

In relation to domestic abuse, we cannot say that nurses find the issue compelling or fascinating. What we can say however, is that domestic abuse does not appear to evoke a state of abjection in all nurses. Not all are powerless to act in the face of domestic abuse and most nurses regard domestic abuse as an important part of their role, particularly regards identification and screening (Dickson & Tutty 1996, Mezey *et al.* 2003, Barnett 2005). So amidst the narratives of shock, horror and inappropriate responses, there are many examples of effective nursing practice, where nurses go to great lengths to secure the safety – both physical and emotional - of women in their care (Bradbury-Jones et al. 2011, *author reference*).

The following midwife's description of care illustrates the nature of a compassionate, supportive response, while reinforcing the transgressive nature of domestic abuse. The midwife recounts her response to a pregnant woman who disclosed that she had been raped by her partner immediately following her previous birth:

I said to her "Are you able to speak about what he's done because we're going to be quite intimate with the examinations that we use". She said to me "I have no sensation or feeling and I have incontinence", because after she was sutured, her past partner raped her and removed the stitches and she bled and bled and bled for days and he wouldn't allow the midwife in or anybody in to make sure she was okay. He used to keep her locked up in the house... So I said to her I wouldn't look at her then and we'd do it a bit further down the road [later] when she'd spoken about it more and come to terms with it more.

Limitations and critique

There are three limiting factors associated with this paper, broadly concerned with: underpinning philosophy, nature of content and scope. We have been inspired by Julia Kristeva's work on the powers of horror (Kristeva 1982). It has assisted in formulating alternative explanations for why nurses respond to domestic abuse in certain ways. As far as we are aware, this is the first paper to study domestic abuse from this angle. However, a 'cautionary word' is required (Rudge & Holmes 2010). The work of Kristeva is contentious. Critics have focused on the inaccessibility of her writing, her unqualified acceptance of Freudian and Lacanian perspectives, her essentialist arguments about femininity and the effectiveness of abjection as an explanatory device (Rudge & Holmes 2010). Cognizance of these criticisms is necessary when appraising the overall utility of this paper.

Regarding nature of content, thinking and reading about abjection (particularly for the first time), can be uncomfortable. Talk of horror and disgust as part of nursing practice may for some, be a step too far. This may be a limitation, but there are advantages. The social and professional constructions of nurses prohibit the verbalization of negative feelings and emotions, so talking of abjection in nursing challenges the idealization of nurses as angels (Holmes et al., 2006). Feelings of disgust as part of nursing practice – and nurse education - are rarely discussed and tend to be silenced (Rudge & Holmes 2009). However, Latimer (2010) refers to ‘unveiling the abject’. In this she argues that viewing nursing practice through the lens of abjection helps us to rethink the cultural and social meanings of many aspects of nursing, including the construction of stigma. It provides opportunity for these to be unwritten and for horror itself to be defaced (Latimer 2010). Moreover, dealing openly with disgust, repulsion and fear, is essential if nurses wish to understand the implications of these on their clinical practice (Jacob et al., 2009, Rudge & Holmes 2009, McCabe & Holmes 2011, Bradbury-Jones 2012).

Finally in terms of scope, we have focused our discussion on domestic abuse as a transgressive practice. Richer analysis may have been derived by extending this to include other forms of abuse, such as child abuse. Domestic abuse and child abuse are closely related (Lazenbatt & Thompson-Cree MEM 2009), so weaving a discussion about the two issues together may have been interesting and relevant. However, for the sake of clarity we chose to explore the singular issue of domestic abuse. The complexity of child abuse and the abjection that it might evoke in nurses warrants its own analysis.

Conclusions

We have used examples from our own domestic abuse research to show how health professionals talk about domestic abuse in terms of horror. We have argued that domestic

abuse (the abject) transgresses established social boundaries of clean and proper and when exposed to patients' and clients' experiences of it, some health professionals subconsciously reject domestic abuse as a possibility (abjection). In so doing, they render themselves unable to formulate appropriate responses in either recognizing or responding to domestic abuse. We have used this theoretical perspective as a new lens through which to view health professionals' responses to domestic abuse. We hope that thinking with (Puig de la Bellacasa 2012) the concept of abjection has added a further explanatory layer when unpacking those responses. It may be helpful to consider abjection when developing supportive strategies for nurses who deal with domestic abuse.

Our study showed how supporting women through domestic abuse experiences places considerable emotional labour upon nurses. As one of the nurses who took part explained, it is only through talking and getting the support, that the burden can be lightened. This elucidates the need for nurses to be supported emotionally when faced with the horrors of abuse. Unfortunately however, although emotions are an important part of nursing practice, the culture of nursing is such that their importance is rarely recognized (Smith & Allan 2010). There is some argument that unrecognized abjection among nurses can have a negative impact of their therapeutic relationships (Jacob et al., 2009). What becomes important then, is nurses' recognition of its existence. This calls for discussions about negative feelings to become an embedded part of nursing culture, rather than a hidden issue. It also requires acceptance that domestic abuse *is* a transgressive practice. As such it is understandable that nurses are disgusted or repelled by it. Paradoxically, if domestic abuse did not evoke a state of abjection in nurses, then one may sensibly question why not?

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